Ab PSy 2 - A lesson on abnormal psychology disorders.

abnormal psych (Bulacan State University)

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UNIT TWO: Clinical Mental Disorders

"Sometimes real superheroes live in the hearts of small children fighting big battles."
—Anonymous

CHAPTER 1

1.1 Objectives

1.2 Self-Assessment # 5

1.3 Lesson One: Neurodevelopmental Disorders

1.3.1 Intellectual Disorders

1.3.2 Communication Disorders

1.3.3 Autism Spectrum Disorders

1.3.4 Attention Deficit Hyperactivity Disorders

1.3.5 Specific Learning Disorders

1.3.6. Motor Disoders

1.3.7 Self-Test # 7

1.4 Learning Insights

1.5. Chapter Questions

1. 6. Suggested Readings

Mental disorders are conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental disorders are associated with distress and/or problems functioning in social, work or family activities. Mental disorders take many forms. Some are *mild* and only interfere in limited ways with daily life, such as certain phobias (abnormal fears). Other mental health conditions are so *severe* that a person may need care in a hospital.

1.1 Objectives

After reading this chapter, you will be able to:

1. Define neurodevelopmental disorders;
2. Describe the different types of these disorders;
3. Explain the etiology (causes) of these disorders; and
4. Describe the different types of treatment for these disorders.

MENTAL DISORDERS ARE NOT ADJECTIVES.
my mom yelled at me yesterday! She's so BIPOLAR!
YOU ALMOST GAVE ME A PANIC ATTACK!
YOU LOOK SO ANOREXIC!
Quit being psycho!
my O.C.D. is coming out again!
Oh yeah, yesterday I was feeling really Depressed.
I swear I'm like retarded!
I stayed up until 1 a.m. my insomnia is SO BAD!

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1.2 Self-Assessment # 5

Neurodevelopmental Disorders

Read the following account and reflect on the questions below.

Case 1

Jonjon is 8 years old and has been referred because both his teachers and parents are concerned by what they describe as his 'strange behavior'. He has always been a solitary child and doesn't have many friends. He likes to collect pebbles that he arranges in lines in his bedroom. He barks and makes high-pitched squeaks for no apparent reason. What bothers his parents most is that he will have tantrums for no obvious reason and he doesn't respond to being punished or rewarded. He is in mainstream school and seems to enjoy it, although he is '...often in a world of his own'. He loves copying cartoon characters in great detail. At assessment he makes no eye contact with you, but tells you all about his pebble collection. His grammar and vocabulary seem normal, but his speech is stilted and he doesn't seem to realize that you are losing interest in what he is saying.

Thought Questions:

1. Based on what has been stated above, what must be your preferred diagnosis of Jonjon's case?

2. What could be your treatment options?

3. What do you think would be the best predictors of a good case outcome (prognosis)?

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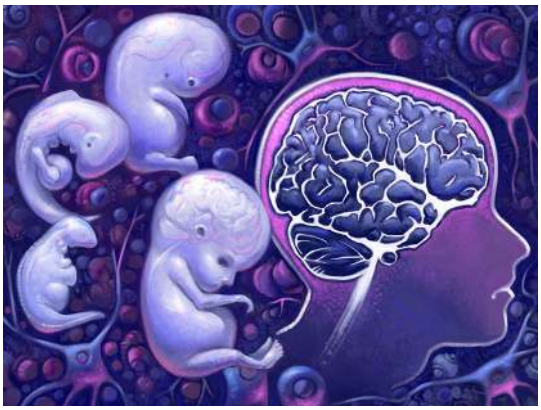
1.3 LESSON 1: Neurodevelopmental Disorders

The neurodevelopmental disorders are a group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning.



The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. The neurodevelopmental disorders frequently co-occur; for example, individuals with autism spectrum disorder often have intellectual disability (intellectual developmental disorder), and many children with attention-deficit/hyperactivity disorder (ADHD) also have a specific learning disorder.

For some disorders, the clinical presentation includes symptoms of excess as well as deficits and delays in achieving expected milestones. For example, autism spectrum disorder is diagnosed only when the characteristic deficits of social communication are accompanied by excessively repetitive behaviors, restricted interests, and insistence on sameness.

1.3.1 Intellectual Disability

Intellectual disability is a term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child.

Children with intellectual disabilities (sometimes called cognitive disabilities or, previously, mental retardation) may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer. There may be some things they cannot learn.

Theories on Intellectual Disability

Researchers have found many causes of intellectual disabilities. The most common are:

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Genetic conditions. Sometimes an intellectual disability is caused by abnormal genes inherited from parents, errors when genes combine, or other reasons. Examples of genetic conditions are Down syndrome, fragile X syndrome, and phenylketonuria (PKU).

Problems during pregnancy. An intellectual disability can result when the baby does not develop inside the mother properly. For example, there may be a problem with the way the baby's cells divide as it grows. A woman who drinks alcohol or gets an infection like rubella during pregnancy may also have a baby with an intellectual disability.

Problems at birth. If a baby has problems during labor and birth, such as not getting enough oxygen, he or she may have an intellectual disability.

Health problems. Diseases like whooping cough, the measles, or meningitis can cause intellectual disabilities. They can also be caused by extreme malnutrition (not eating right), not getting enough medical care, or by being exposed to poisons like lead or mercury.

An intellectual disability is not a disease. You can't catch an intellectual disability from anyone. It's also not a type of mental illness, like depression. There is no cure for intellectual disabilities. However, most children with an intellectual disability can learn to do many things. It just takes them more time and effort than other children.

***Signs of Intellectual Disability*.** There are many signs of an intellectual disability. For example, children with an intellectual disability may:

- sit up, crawl, or walk later than other children;
- learn to talk later, or have trouble speaking,
- find it hard to remember things,
- not understand how to pay for things,
- have trouble understanding social rules,
- have trouble seeing the consequences of their actions,
- have trouble solving problems, and/or
- have trouble thinking logically

Several hundred causes have been discovered, but in about one-third of the people affected, the cause remains unknown. The three major known causes of mental retardation are the genetic conditions of **Down Syndrome**, **Fragile X**, and **Fetal Alcohol Syndrome**, the result of alcohol consumption during pregnancy.

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***Diagnosis of Intellectual Disability*.** Intellectual disabilities are diagnosed by looking at two main things. These are:

1. the ability of a person's brain to learn, think, solve problems, and make sense of the world (called IQ or intellectual functioning); and

2. whether the person has the skills he or she needs to live independently (called adaptive behavior, or adaptive functioning).

Intellectual functioning, or IQ, is usually measured by a test called an IQ test. The average score is 100. People scoring below 70 to 75 are thought to have an intellectual disability. To measure adaptive behavior, professionals look at what a child can do in comparison to other children of his or her age. Certain skills are important to adaptive behavior. These are:

- daily living skills, such as getting dressed, going to the bathroom, and feeding one's self;
- communication skills, such as understanding what is said and being able to answer;
- social skills with peers, family members, adults, and others.

To diagnose an intellectual disability, professionals look at the person's mental abilities (IQ) and his or her adaptive skills. Both of these are highlighted in the definition of this disability within our nation's special education law, the Individuals with Disabilities Education Act (IDEA). IDEA is the federal law that guides how early intervention and special education services are provided to infants, toddlers, children, and youth with disabilities. In IDEA, "intellectual disability" is defined as follows:

Definition of "Intellectual Disability" under IDEA

Until Rosa's Law was signed into law by President Obama in October 2010, IDEA used the term "mental retardation" instead of "intellectual disability." Rosa's Law changed the term to be used in future to "intellectual disability." The definition itself, however, did not change. Accordingly, "intellectual disability" is defined as…

"…significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance." [34 CFR §300.8(c)(6)]

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People with a mild intellectual disability	People with a moderate intellectual disability	People with severe intellectual disability
A mild intellectual disability is defined as an IQ between 50 and 70. A person with a mild intellectual disability: 1.Can participate in and contribute to their family and their community 2. Will have important relationships in their life 3. May find the subtleties of interpersonal relationships and social rules difficult to fully understand. 4. They may sometimes behave awkwardly or inappropriately in social situations 5. May marry and raise children with the support of family, friends and support services 6. May have a job, in either open or supported employment	A moderate intellectual disability is defined as an IQ between 35 and 50. A person with a moderate intellectual disability: 1. Will have important relationships in their life and will probably form valued and lasting friendships 2. Will enjoy a range of activities with their family, friends and acquaintances 3. May be able to learn to travel on regular public transport routes with specific training, but will have difficulty planning trips and handling money.4.They may have great difficulty problem solving when unexpected events occur.	A severe intellectual disability is defined as an IQ between 20 and 35. A profound intellectual disability is defined as an IQ below 20. A person with a severe or profound intellectual disability: 1. Will usually recognize familiar people and may have strong relationships with key people in their life 2. Is likely to have little or no speech, and will rely on gestures, facial expression and body language to communicate needs or feelings.

Global Developmental Delay

Global Developmental Delay (GDD) is reserved for individuals under the age of 5 years when the clinical severity level cannot be reliably assessed during early childhood. It is usually defined by the child being diagnosed with having a lower intellectual functioning than what is perceived as 'normal'. It is usually accompanied by having significant limitations in communication.

The most common signs of GDD include:

1. The child is unable to sit on the floor without support by 8 months;
2. The child is unable to crawl by 12 months;
3. The child has poor social skills/ judgment;
4. The child is unable to roll over by 6 months;
5. The child has communication problems
6. The child has fine/ gross motor difficulties
7. The child shows aggressive behavior as a coping skill

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In some children GDD is suspected soon after birth because of feeding difficulties or muscle-tone. In others it is suspected later when learning or behavior difficulties occur at school.

Treatment of Intellectual Disability

There is no cure for intellectual disability, but services and supports play an important role and can enable the person to thrive throughout their lifetime. Services for people with intellectual disabilities and their families are primarily there to provide adequate support to allow for full inclusion in their communities. These services touch their daily lives (education, justice, housing, recreational, employment, health care, etc.) and may include:

- Family support (for example, respite care)
- Vocational programs
- Day programs
- Residential options
- Early intervention
- Special education
- Transition services

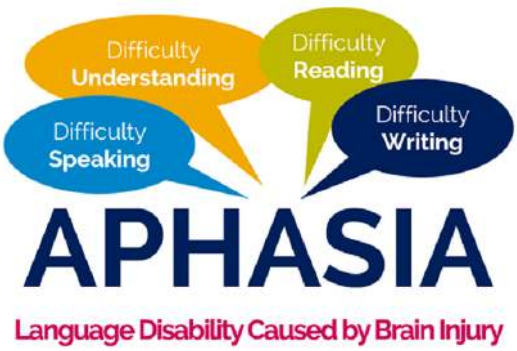
Supports include the resources and individual strategies necessary to promote the development, education, interests, and well-being of a person. Supports can come from family, friends and community or from a service system. Job coaching is an example of a support provided by a service system. Supports can also be provided by a parent, sibling, friend, teacher or any other person, such as a co-worker who provides a little extra support to someone on the job. Supports are provided in many settings, and a "setting" or location by itself is not a support.

1.3.2 Communication Disorders

Communication disorders include problems related to speech, language and auditory processing. Communication disorders may range from simple sound repetitions such as stuttering to occasional misarticulating of words to complete inability to use speech and language for communications (aphasia).

Aphasia

Aphasia is loss of the ability to produce or comprehend language. There are acute aphasias which result from stroke or brain injury, and primary progressive aphasias caused by



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progressive illnesses such as dementia.

Learning disability

- Dyscalculia – a defect of the systems used in communicating numbers
- Dyslexia – a defect of the systems used in reading
- Dysgraphia – a defect in the systems used in writing

Speech disorders

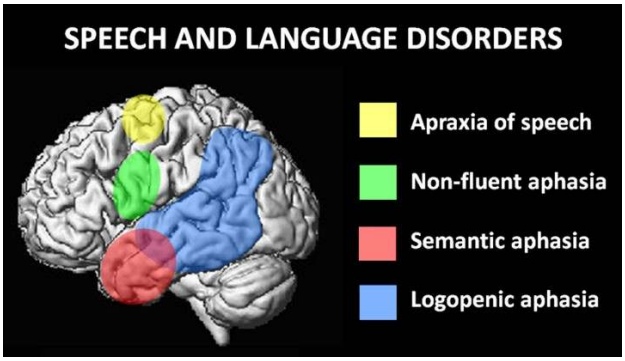
- cluttering - a syndrome characterized by a speech delivery rate which is either abnormally fast, irregular, or both.
- dysarthria - a condition that occurs when problems with the muscles that help you talk make it difficult to pronounce words.
- esophageal voice - involves the patient injecting or swallowing air into the esophagus. Once the patient has forced the air into their esophagus, the air vibrates a muscle and creates esophageal voice. Esophageal voice tends to be difficult to learn and patients are often only able to talk in short phrases with a quiet voice.

- lisp - a speech impediment that is also known as sigmatism.
- speech sound disorder - Speech-sound disorders (SSD) involve impairments in speech-sound production and range from mild articulation issues involving a limited number of speech sounds to more severe phonologic disorders involving multiple errors in speech-sound production and reduced intelligibility.
- stuttering - a speech disorder in which sounds, syllables, or words are repeated or last longer than normal. These problems cause a break in the flow of speech (called disfluency.

Language Disorder

Language disorder is a neurodevelopment condition with onset during childhood development, with the core diagnostic features of difficulties in the acquisition and use of language due to deficits in the comprehension or production of vocabulary, sentence structure, and discourse. More specifically include the following:

1. Reduced vocabulary (word knowledge and use).



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2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).

3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).

Most children make some mistakes as they learn to say new words. A speech sound disorder occurs when mistakes continue past a certain age. Every sound has a different range of ages when the child should make the sound correctly. Speech sound disorders include problems with articulation (making sounds) and phonological processes (sound patterns). Adults can also have speech sound disorders. Some adults continue to have problems from childhood, while others may develop speech problems after a stroke or head injury. (Cf. apraxia of speech and dysarthria).

Young children often make speech errors. For instance, many young children sound like they are making a "w" sound for an "r" sound (e.g., "wabbit" for "rabbit") or may leave sounds out of words, such as "nana" for "banana." The child may have an articulation disorder if these errors continue past the expected age.

A phonological process disorder involves patterns of sound errors. For example, substituting all sounds made in the back of the mouth like "k" and "g" for those in the front of the mouth like "t" and "d" (e.g., saying "tup" for "cup" or "das" for "gas").

Childhood-Onset Fluency Disorder

The essential feature of ***Stuttering*** is a disturbance in the normal fluency and time patterning of speech that is inappropriate for the individual's age. This disorder is most commonly diagnosed in childhood.

At the onset of Stuttering, the speaker may not be aware of the problem, although awareness and even fearful anticipation of the problem may develop later. The speaker may attempt to avoid stuttering by linguistic mechanisms (e.g., altering the rate of speech, avoiding certain speech situations such as telephoning or public speaking, or avoiding certain words or sounds). Stuttering may be accompanied by motor movements (e.g., eye blinks, tics, tremors of the lips or face, jerking of the head, breathing movements, or fist clenching).

Stress or anxiety have been shown to exacerbate Stuttering. Impairment of social functioning may result from associated anxiety, frustration, or low self-esteem. In adults, stuttering may limit occupational choice or advancement. Phonological Disorder and Expressive Language Disorder occur at a higher frequency in individuals with Stuttering than in the general population.

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Social (Pragmatic) CommunicationDisorder

Social (pragmatic) communication disorder is characterized by difficulty with the use of social language and communication skills (also called by professionals pragmatic communication). A child or teen with this disorder will have difficulty in following the ordinary social rules of communication(whether they are verbal or nonverbal), following the rules for storytelling or conversations (each person takes a turn), and changing language depending upon the situation or needs of the listener.

These kinds of problems in social communication lead to the child having a difficult time communicating effectively with others, participating in a social manner with others, and can even affect academic performance.

This disorder is most commonly diagnosed by age 5, since most children should possess adequate speech and language abilities by that time.

1.3.3 Autism Spectrum Disorders

There is considerable overlap among the different forms of autism. The wide variation in symptoms among children with autism, however, has led to the concept of ***autism spectrum disorder***, or **ASD**. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: *autistic disorder*, *pervasive developmental disorder* not otherwise specified (PDD-NOS), and *Asperger syndrome*. These conditions are now all called autism spectrum disorder.

A **spectrum** as it applies to mental disorder is a range of linked conditions, sometimes also extending to include singular symptoms and traits. A spectrum approach is taken because there appears to be not a unitary disorder but rather a syndrome composed of subgroups.

Autism spectrum disorder (ASD) and autism are both general terms for a group of complex disorders of brain development. These disorders are characterized, in varying

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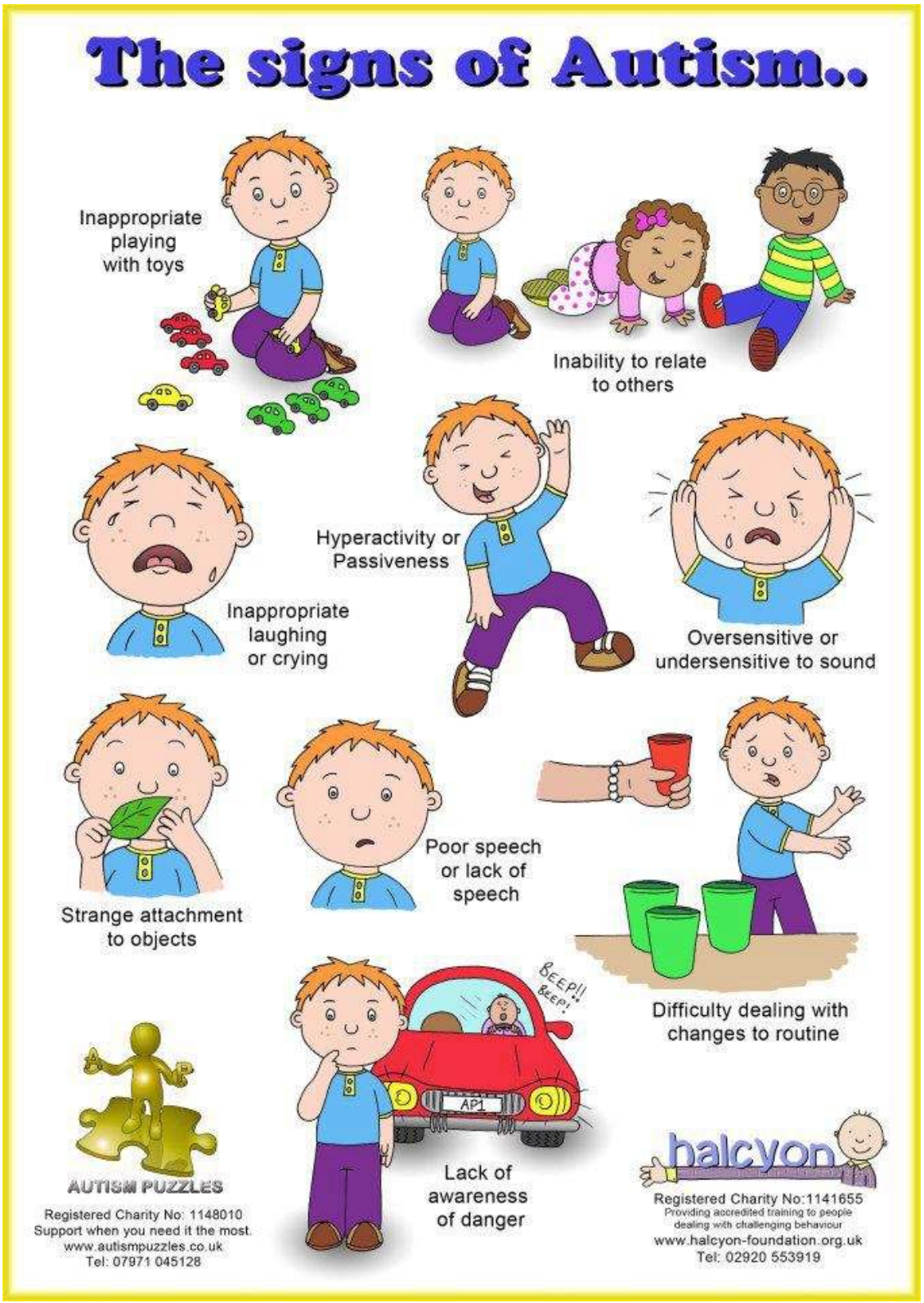

degrees, by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviors. With the May 2013 publication of the DSM-5 diagnostic manual, all autism disorders were merged into one umbrella diagnosis of ASD. Previously, they were recognized as distinct subtypes, including autistic disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS) and Asperger syndrome.

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ASD can be associated with intellectual disability, difficulties in motor coordination and attention and physical health issues such as sleep and gastrointestinal disturbances. Some persons with ASD excel in visual skills, music, math and art.

Causes of Autism

Not long ago, the answer to this question would have been "we have no idea." Research is now delivering the answers. First and foremost, we now know that there is no one cause of autism just as there is no one type of autism. Over the last five years, scientists have identified a number of rare gene changes, or mutations, associated with autism. A small number of these are sufficient to cause autism by themselves. Most cases of autism, however, appear to be caused by a combination of autism risk genes and environmental factors influencing early brain development.

In the presence of a genetic predisposition to autism, a number of non-genetic, or "environmental," stresses appear to further increase a child's risk. The clearest evidence of these autism risk factors involves events before and during birth. They include advanced parental age at time of conception (both mom and dad), maternal illness during pregnancy and certain difficulties during birth, particularly those involving periods of oxygen deprivation to the baby's brain. It is important to keep in mind that these factors, by themselves, do not cause autism. Rather, in combination with genetic risk factors, they appear to modestly increase risk.

A growing body of research suggests that a woman can reduce her risk of having a child with autism by taking prenatal vitamins containing folic acid and/or eating a diet rich in folic acid (at least 600 mcg a day) during the months before and after conception.

Treatment of Autism

There is no cure for ASDs. Therapies and behavioral interventions are designed to remedy specific symptoms and can bring about substantial improvement. The ideal treatment plan coordinates therapies and interventions that meet the specific needs of individual children. Most health care professionals agree that the earlier the intervention, the better.

Educational/behavioral interventions: Therapists use highly structured and intensive skill-oriented training sessions to help children develop social and language skills, such as Applied Behavioral Analysis. Family counseling for the parents and siblings of children with an ASD often helps families cope with the particular challenges of living with a child with an ASD.

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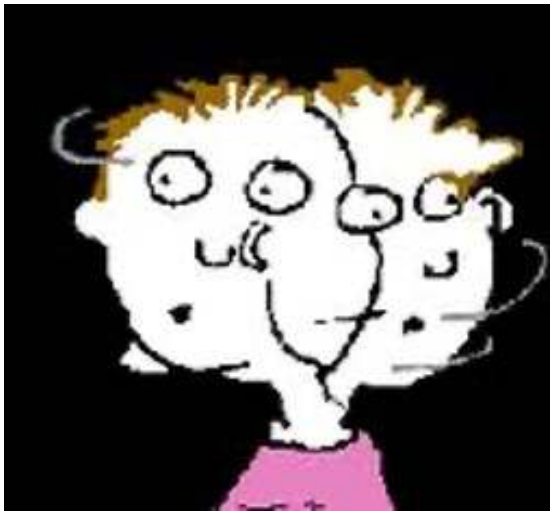
Medications: Doctors may prescribe medications for treatment of specific autism-related symptoms, such as anxiety, depression, or obsessive-compulsive disorder. Antipsychotic medications are used to treat severe behavioral problems. Seizures can be treated with one or more anticonvulsant drugs. Medication used to treat people with attention deficit disorder can be used effectively to help decrease impulsivity and hyperactivity.

Other therapies: There are a number of controversial therapies or interventions available, but few, if any, are supported by scientific studies. Parents should use caution before adopting any unproven treatments. Although dietary interventions have been helpful in some children, parents should be careful that their child's nutritional status is carefully followed.

1.3.4 Attention Deficits and Hyperactivity Disorders

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

ADHD has three subtypes:



Predominantly hyperactive-impulsive

Most symptoms (six or more) are in the hyperactivity-impulsivity categories.

Fewer than six symptoms of inattention are present, although inattention may still be present to some degree.

Predominantly inattentive

The majority of symptoms (six or more) are in the inattention category and fewer than six symptoms of hyperactivity-impulsivity are present, although hyperactivity-impulsivity may still be present to some degree.

Children with this subtype are less likely to act out or have difficulties getting along with other children. They may sit quietly, but they are not paying attention to what they are doing. Therefore, the child may be overlooked, and parents and teachers may not notice that he or she has ADHD.

Combined hyperactive-impulsive and inattentive

Six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity are present.

Most children have the combined type of ADHD.

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Causes of ADHD

Scientists are not sure what causes ADHD, although many studies suggest that genes play a large role. Like many other illnesses, ADHD probably results from a combination of factors. In addition to genetics, researchers are looking at possible environmental factors, and are studying how brain injuries, nutrition, and the social environment might contribute to ADHD.

Genes. Results from several international studies of twins show that ADHD often runs in families. Researchers are looking at several genes that may make people more likely to develop the disorder. Knowing the genes involved may one day help researchers prevent the disorder before symptoms develop. Learning about specific genes could also lead to better treatments.

Children with ADHD who carry a particular version of a certain gene have thinner brain tissue in the areas of the brain associated with attention. This NIMH research showed that the difference was not permanent, however, and as children with this gene grew up, the brain developed to a normal level of thickness. Their ADHD symptoms also improved.

Environmental factors. Studies suggest a potential link between cigarette smoking and alcohol use during pregnancy and ADHD in children. In addition, preschoolers who are exposed to high levels of lead, which can sometimes be found in plumbing fixtures or paint in old buildings, may have a higher risk of developing ADHD.

Brain injuries. Children who have suffered a brain injury may show some behaviors similar to those of ADHD. However, only a small percentage of children with ADHD have suffered a traumatic brain injury.

Sugar. The idea that refined sugar causes ADHD or makes symptoms worse is popular, butt more research discounts this theory than supports it. In one study, researchers gave children foods containing either sugar or a sugar substitute every other day. The children who received sugar showed no different behavior or learning capabilities than those who

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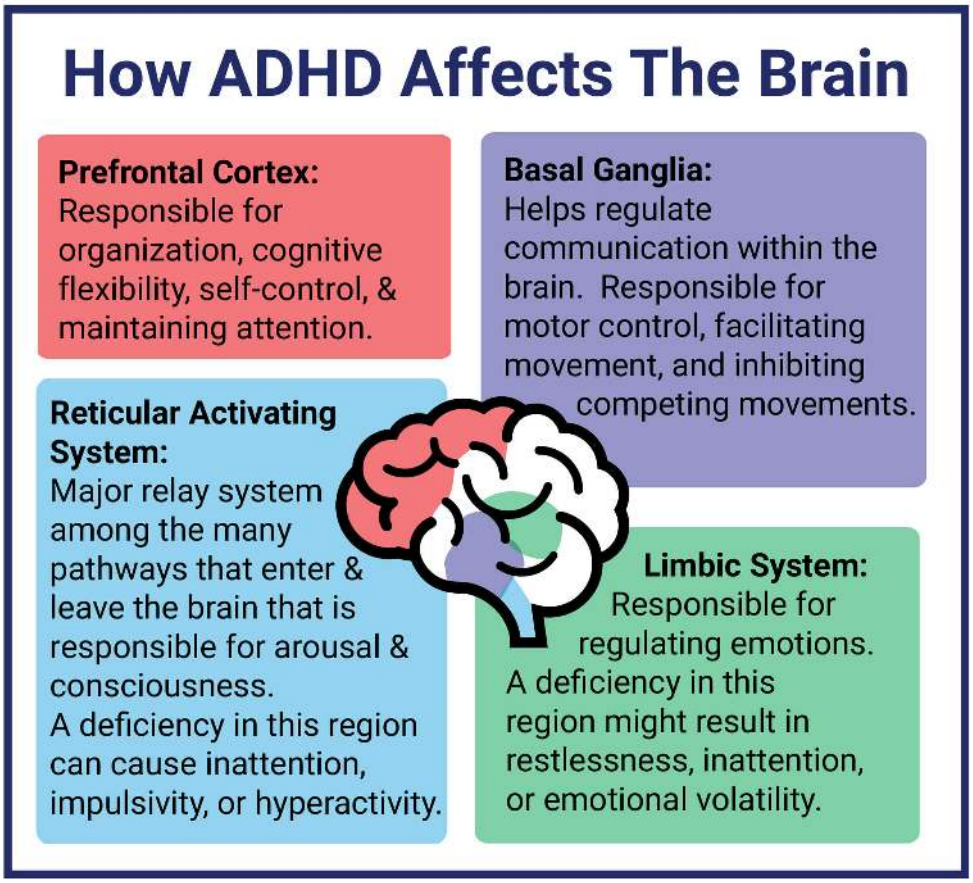
received the sugar substitute. Another study in which children were given higher than average amounts of sugar or sugar substitutes showed similar results.


How ADHD Affects The Brain
Prefrontal Cortex:
Responsible for organization, cognitive flexibility, self-control, & maintaining attention.
Basal Ganglia:
Helps regulate communication within the brain. Responsible for motor control, facilitating movement, and inhibiting competing movements.
Reticular Activating System:
Major relay system among the many pathways that enter & leave the brain that is responsible for arousal & consciousness.
A deficiency in this region can cause inattention, impulsivity, or hyperactivity.
Limbic System:
Responsible for regulating emotions.
A deficiency in this region might result in restlessness, inattention, or emotional volatility.

In another study, children who were considered sugar-sensitive by their mothers were given the sugar substitute aspartame, also known as Nutrasweet. Although all the children got aspartame, half their mothers were told their children were given sugar, and the other half were told their children were given aspartame. The mothers who thought their children had gotten sugar rated them as more hyperactive than the other children and were more critical of their behavior, compared to mothers who thought their children received aspartame.

Food additives. Recent British research indicates a possible link between consumption of certain food additives like artificial colors or preservatives, and an increase in activity. Research is under way to confirm the findings and to learn more about how food additives may affect hyperactivity.

Symptoms of ADHD

Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD. It is normal for all children to be inattentive, hyperactive, or impulsive sometimes, but for children with ADHD, these behaviors are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for 6 or more months and to a degree that is greater than other children of the same age.

Children who have symptoms of inattention may:

Be easily distracted, miss details, forget things, and frequently switch from one activity to another

Have difficulty focusing on one thing

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Become bored with a task after only a few minutes, unless they are doing something enjoyable

Have difficulty focusing attention on organizing and completing a task or learning something new

Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities

Not seem to listen when spoken to

Daydream, become easily confused, and move slowly

Have difficulty processing information as quickly and accurately as others

Struggle to follow instructions.

Children who have symptoms of hyperactivity may:

Fidget and squirm in their seats

Talk nonstop

Dash around, touching or playing with anything and everything in sight

Have trouble sitting still during dinner, school, and story time

Be constantly in motion

Have difficulty doing quiet tasks or activities.

Children who have symptoms of impulsivity may:

Be very impatient

Blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences

Have difficulty waiting for things they want or waiting their turns in games

Often interrupt conversations or others' activities.

ADHD Can Be Mistaken for Other Problems

Parents and teachers can miss the fact that children with symptoms of inattention have the disorder because they are often quiet and less likely to act out. They may sit quietly, seeming to work, but they are often not paying attention to what they are doing. They may get along well with other children, compared with those with the other subtypes, who tend to have social problems. But children with the inattentive kind of ADHD are not the only ones whose disorders can be missed. For example, adults may

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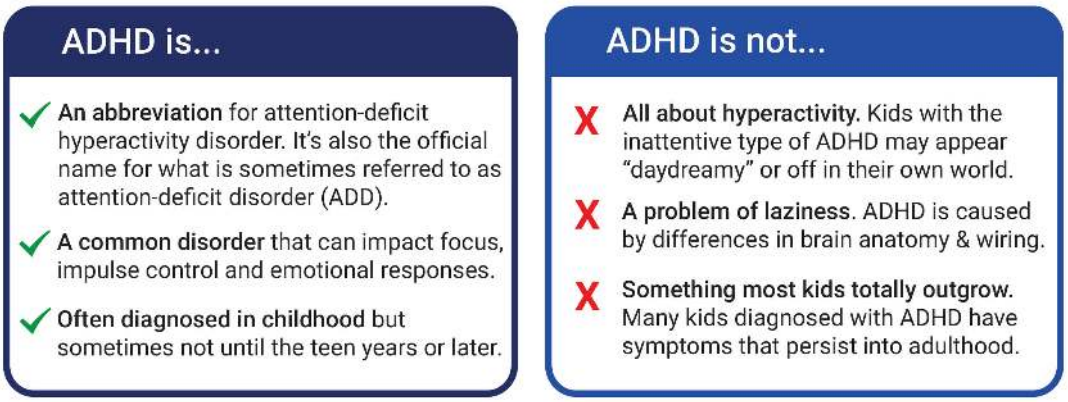
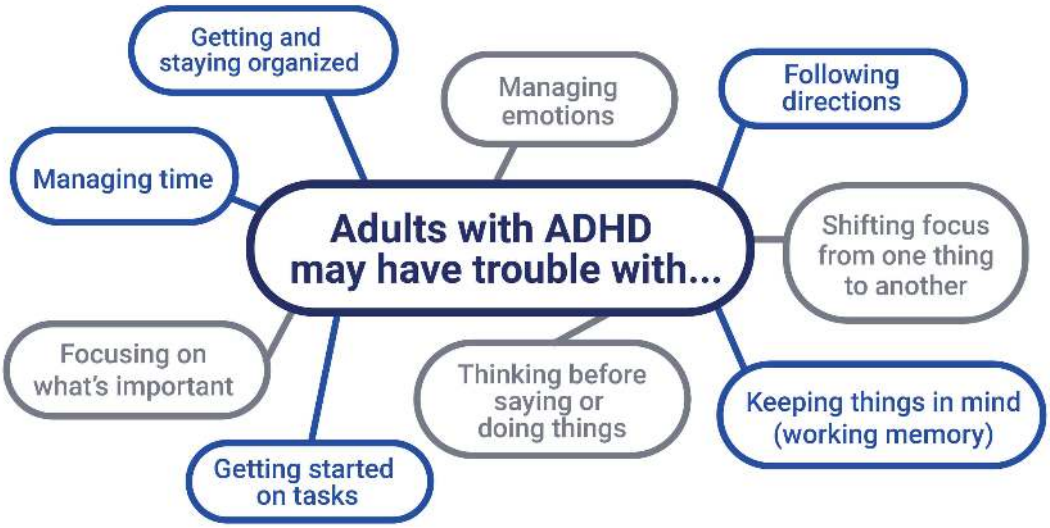
think that children with the hyperactive and impulsive subtypes just have emotional or disciplinary problems.


ADHD is...
An abbreviation for attention-deficit hyperactivity disorder. It's also the official name for what is sometimes referred to as attention-deficit disorder (ADD).
A common disorder that can impact focus, impulse control and emotional responses.
Often diagnosed in childhood but sometimes not until the teen years or later.
ADHD is not...
All about hyperactivity. Kids with the inattentive type of ADHD may appear "daydreamy" or off in their own world.
A problem of laziness. ADHD is caused by differences in brain anatomy & wiring.
Something most kids totally outgrow. Many kids diagnosed with ADHD have symptoms that persist into adulthood.


Adults with ADHD may have trouble with...
Getting and staying organized
Managing emotions
Following directions
Managing time
Shifting focus from one thing to another
Focusing on what's important
Thinking before saying or doing things
Keeping things in mind (working memory)
Getting started on tasks

Current medications do not cure ADHD. Rather, they control the symptoms for as long as they are taken. Medications can help a child pay attention and complete schoolwork. It is not clear, however, whether medications can help children learn or improve their academic skills. Adding behavioral therapy, counseling, and practical support can help children with ADHD and their families to better cope with everyday problems. Research funded by the National Institute of Mental Health (NIMH) has shown that medication works best when treatment is regularly monitored by the prescribing doctor and the dose is adjusted based on the child's needs.

Psychotherapy

Different types of psychotherapy are used for ADHD. Behavioral therapy aims to help a child change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult

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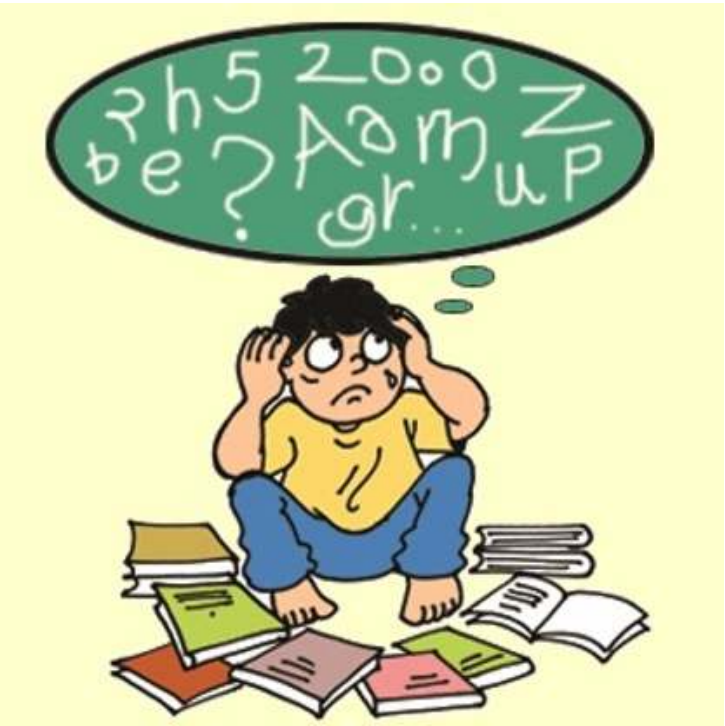
events. Behavioral therapy also teaches a child how to monitor his or her own behavior. Learning to give oneself praise or rewards for acting in a desired way, such as controlling anger or thinking before acting, is another goal of behavioral therapy. Parents and teachers also can give positive or negative feedback for certain behaviors. In addition, clear rules, chore lists, and other structured routines can help a child control his or her behavior.

Therapists may teach children social skills, such as how to wait their turn, share toys, ask for help, or respond to teasing. Learning to read facial expressions and the tone of voice in others, and how to respond appropriately can also be part of social skills training.

1.3.5 Specific Learning Disorders

Specific learning disorder is diagnosed through a clinical review of the individual's developmental, medical, educational, and family history, reports of test scores and teacher observations, and response to academic interventions. The diagnosis requires persistent difficulties in reading, writing, arithmetic, or mathematical reasoning skills during formal years of schooling. Symptoms may include inaccurate or slow and effortful reading, poor written expression that lacks clarity, difficulties remembering number facts, or inaccurate mathematical reasoning.



Current academic skills must be well below the average range of scores in culturally and linguistically appropriate tests of reading, writing, or mathematics. The individual's difficulties must not be better explained by developmental, neurological, sensory (vision or hearing), or motor disorders and must significantly interfere with academic achievement, occupational performance, or activities of daily living.

Because of the changes in DSM-5, clinicians will be able to make this diagnosis by identifying whether patients are unable to perform academically at a level appropriate to their intelligence and age. After a diagnosis, clinicians can provide greater detail into the type of deficit(s) that an individual has through the designated specifiers. Just as in DSM-IV, dyslexia will be included in the descriptive text of specific learning disorder. The DSM-5 Neurodevelopmental Work Group concluded that the many definitions of dyslexia and dyscalculia meant those terms would not be useful as disorder names or in the diagnostic criteria.

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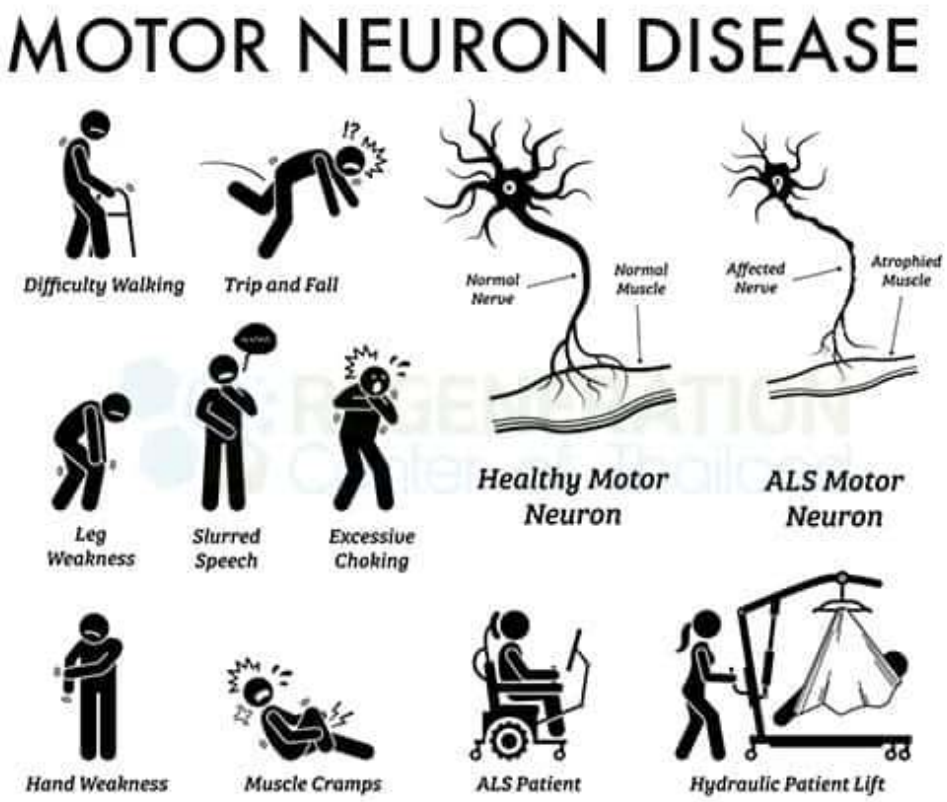
1.3.6 Motor Disorders

The motor neuron diseases (MNDs) are a group of progressive neurological disorders that destroy motor neurons, the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. Normally, messages from nerve cells in the brain (called upper motor neurons) are transmitted to nerve cells in the brain stem and spinal cord (called lower motor neurons) and from them to particular muscles. Upper motor neurons direct the lower motor neurons to produce movements such as walking or chewing. Lower motor neurons control movement in the arms, legs, chest, face, throat, and tongue. Spinal motor neurons are also called anterior horn cells. Upper motor neurons are also called corticospinal neurons.



When there are disruptions in the signals between the lowest motor neurons and the muscle, the muscles do not work properly; the muscles gradually weaken and may begin wasting away and develop uncontrollable twitching (called fasciculations). When there are disruptions in the signals between the upper motor neurons and the lower motor neurons, the limb muscles develop stiffness (called spasticity), movements become slow and effortful, and tendon reflexes such as knee and ankle jerks become overactive. Over time, the ability to control voluntary movement can be lost. **Amyotrophic lateral sclerosis (ALS)** is the most well-known type of neurological disorder in the MND family. Famous cases of people with MND include Stephen Hawking, David Niven and Lou Gehrig.

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Tendency to fall, trip, bump into things
Lack of rhythm when dancing and doing aerobics
Gross motor co-ordination difficulties, e.g. poor balance and posture
Difficulties interpreting body language
Poor integration of the two sides of the body
What are the signs?
Poor spatial skills, gets lost easily
Poor hand-eye co-ordination
Weak memory, especially short-term memory
Poor time management and organisational skills
Fine motor co-ordination difficulties, e.g. handwriting, typing, drawing
Difficulties with the organisation and manipulation of thought and language

Developmental Coordination Disorder

Developmental coordination disorder (DCD) also known as developmental *dyspraxia* is a chronic neurological disorder beginning in childhood that can affect planning of movements and co-ordination as a result of brain messages not being accurately transmitted to the body. It may be diagnosed in the absence of other motor or sensory impairments like cerebral palsy, muscular dystrophy, multiple sclerosis or Parkinson's disease.

Stereotypic Movement Disorder

Stereotypic movement disorder is a condition in which a person makes repetitive, purposeless movements (such as hand waving, body rocking, or head banging) for at least four weeks. The movements interfere with normal activity or have the potential to cause bodily harm.

Stereotypic movement disorder is more common among boys than girls. The repetitive movements appear to increase with stress, frustration, and boredom. The cause of this disorder, when it occurs in the absence of other conditions, is unknown.

Stimulants such as cocaine and amphetamines can prompt a severe, but short period of stereotypic movement behavior. The behavior may include repetitive and purposeless picking, hand wringing, head tics, or lip-biting. Long-term abuse of stimulants

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may lead to longer periods of stereotypic movement behavior. Head injuries may also cause stereotypic movements.

Symptoms

Biting self

Hand shaking or waving

Head banging

Hitting own body

Mouthing of objects

Nail biting

Rocking

Treatments

Treatments should focus on the cause, specific symptoms, and patient's age. The environment should be changed so that it is safer for patients who cause injury to themselves. Behavioral techniques and psychotherapy have been the most successful treatment methods. Some medications, including naltrexone, may also help reduce symptoms related to this condition. Antidepressants have been used in some cases.

Tic Disorder

Tics are involuntary twitches that may involve any voluntary muscle groups. Tics may be partially controlled, usually for a short duration during which a person makes a strong effort to control them. Later, however, the tics will reoccur and may be stronger due to the compensation attempt. Tics may consist of eye blinking, facial grimacing, nasal flaring, or mouth opening. To best understand how a person with a tic disorder feels, one may try to refrain from blinking his own eyes for a long period of time. This will be easy initially, but after about 30 seconds the blinking will occur almost automatically. This is how a person with a tic disorder feels constantly. Tics become worse when people are under stressful situations. Usually presenting for the first time when a family emergency or a move from a safe environment occurs.

Tics may be *motor* or *vocal*; the vocal tics include humming, grunting, or saying actual words, usually in an explosive, spastic fashion, (the words may be curses). Tics may be simple or complex. A simple tic is purposeless, such as an eye blink, any other muscle twitch, a grunt, or a production of a noise. A complex tic consists of a muscle movement with a purpose, such as scratching, throwing, or chewing. A vocal complex tic is one that actually produces a word, not just a sound.

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The most complicated and concerning tic disorder is ***Tourette's disorder.*** This disorder requires the presence of tics for at least 1 year. The tics must be motor and vocal in nature. The tics must be frequent, never stopping for a period of longer than 2 months. They also must be causing a significant impairment. Tourette's disorder is a combination of multiple tics, AD/HD like symptoms, and obsessive-compulsive difficulties.

Chronic motor tic disorder: same as Tourette's except not associated with vocal tics

Chronic vocal tic disorder: same as Tourette's except consists only of vocal tics (no motor tics)

Acute tic disorder: a disorder consisting of tics, lasting a short time and resolves when the causative stress factor is eliminated (lasts less than 3 months).

Tic disorder not otherwise specified: includes all the other disorders that do not meet the criteria for the above-mentioned disorders.

Tourette's Disorder

This is a disorder of a combination of both vocal and motor tics. It should be considered a part of a behavioral disorder spectrum that consists of tics, obsessive-compulsive behavior, and attention deficit hyperactivity disorder. In order to qualify for the diagnosis of Tourette's disorder the tics must be present for over 1 year and never resolve for a period longer than 2 months. The natural course of the disorder is fluctuating. The fluctuations of the symptoms may or may not be related to stress factors.

Treatment for Tourette's Syndrome

Most children with tics do not require treatment. The fluctuating course of the disorder makes waiting a prudent choice; it also makes it difficult to clearly assess response to the medications, since a regular fluctuation rather than medication effects may cause worsening or improvements. When treatment is considered, different neurologists may have some slightly different approaches.

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Name: Year & Section:

1.3.7 SELF-TEST # 7

I. ***DIAGNOSTICS***: Label the disorder that the client had.

_____ 1. Among 18-has experienced a variety of movements of the face and upper body since age 5. His movements initially consisted of facial grimacing, frequent blinking, and puckering of the lips.

_____ 2. Betty 5th grade, was always considered a little slower than his peers, but he was a likable child who got along well with family members and friends. When academic work became demanding and she fell behind in 2nd grade, the school conducted an evaluation. She has lower IQ and still has problem in getting dress.

_____ 3. Caloy knew about 10 approximate signs when asked to label, but these were not used in a communicative fashion. Protests were demonstrated most often through pushing hands. He played functionally with toys when seated and used eye gaze appropriately during cause-and-effect play, but otherwise eye gaze was absent. He often appeared to be non-engaged and responded inconsistently to his name.

_____ 4. Dodong cannot maintain one to one correspondence with objects while counting. During both individual and group instruction, he frequently interrupts to ask unrelated questions and change. When interacting with peers, he constantly changes topics and commonly leaves an activity or game while others continue to play.

_____ 5. Egay speech were the natural repetitions of syllables and words. At first they were few and seemed to appear when he was excited or distressed. Gradually the repetitions began to occur more frequently and they became much more severe, hard, struggle type of forcing.

_____ 6. Ferdie, 14-year old, when he was prompted to engage in various tasks that required that he take his hands out of his pockets, he began hitting his head with his hands. If his hands were held by the teacher, he hit his head with his knees.

_____ 7. Gener struggled with articulation errors, reading, and concepts in Math such as understanding the ones and tens place values. It became a growing concern to both his teachers and his parents.

_____ 8. Hanna had difficulty learning the letters of the alphabet in kindergarten as well as trouble with initial sounds, sight vocabulary and rhyming. She had some trouble sequencing story elements and following multiple step instructions when given orally.

_____ 9. Ineng often do not understand that we take turns to talk, and she will "talk over the top of you" at times, or, at other times respond to what you say with inappropriate silences, or in a voice that is too quiet. She may interrupt excessively and talk irrelevantly or about things the listener shows no interest in. She appears rude and inconsiderate.

_____ 10. Jenny explained that when coworkers at school or her family members ask her to speak up, she runs out of breath as she tries to increase her volume for them. She may discontinue giving speeches altogether because she has trouble moving her lips, tongue, and jaw due to decreased range of motion.

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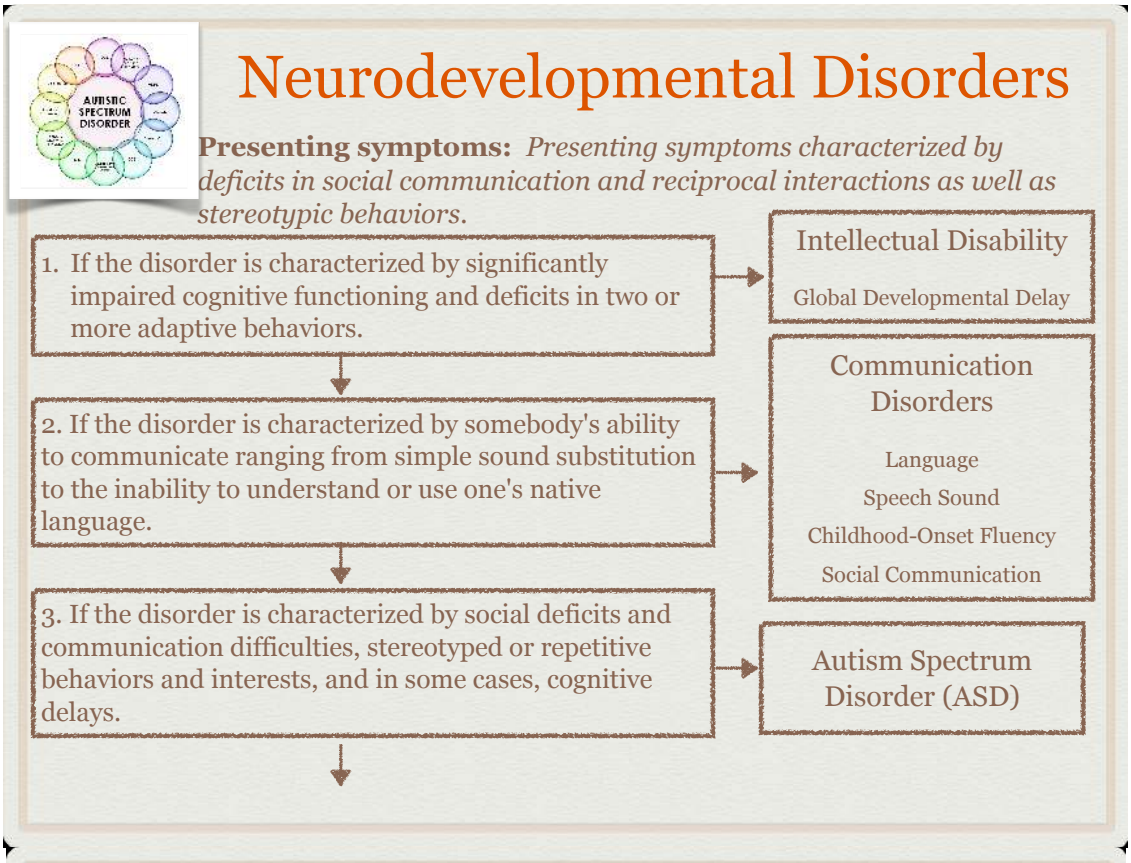
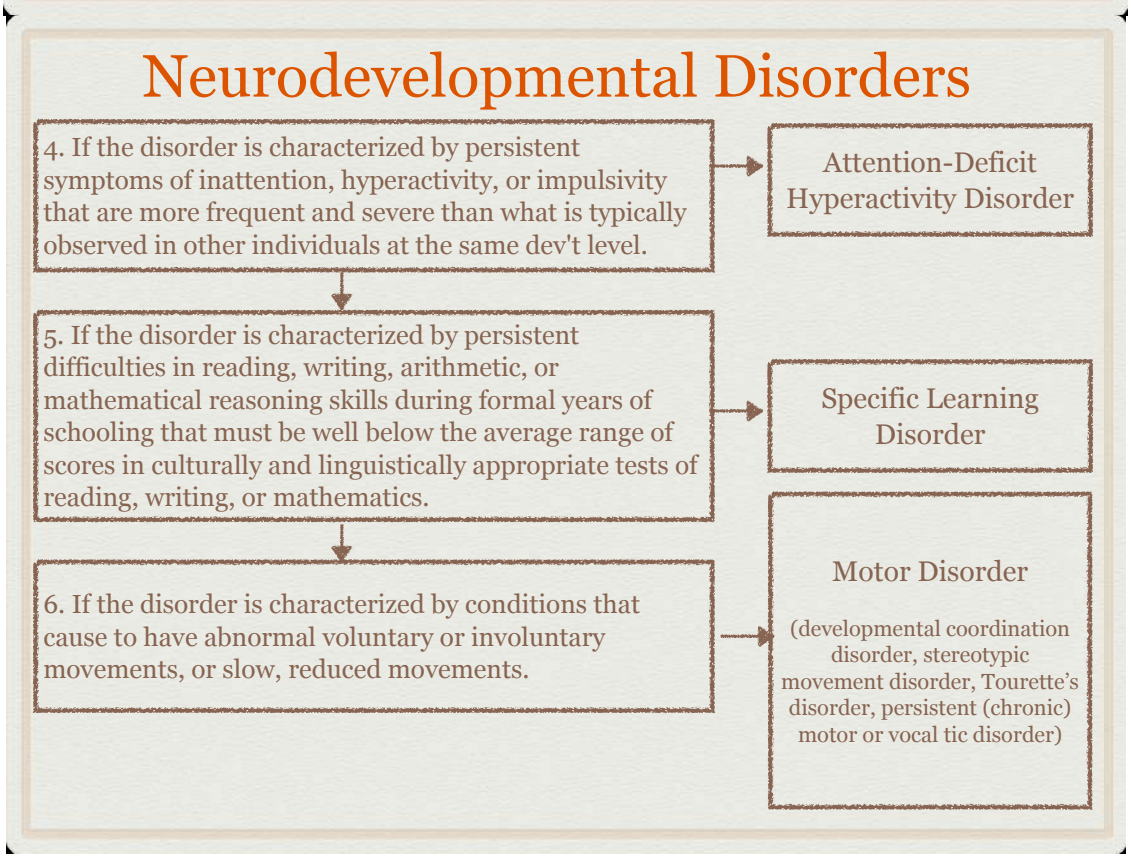
1.4 LEARNING INSIGHTS

Neurodevelopmental disorders according to this provided algorithm can be diagnosed:


Neurodevelopmental Disorders
AUTISTIC SPECTRUM DISORDER
Presenting symptoms: Presenting symptoms characterized by deficits in social communication and reciprocal interactions as well as stereotypic behaviors.
1. If the disorder is characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors.
Intellectual Disability
Global Developmental Delay
2. If the disorder is characterized by somebody's ability to communicate ranging from simple sound substitution to the inability to understand or use one's native language.
Communication Disorders
Language
Speech Sound
Childhood-Onset Fluency
Social Communication
3. If the disorder is characterized by social deficits and communication difficulties, stereotyped or repetitive behaviors and interests, and in some cases, cognitive delays.
Autism Spectrum Disorder (ASD)


Neurodevelopmental Disorders
4. If the disorder is characterized by persistent symptoms of inattention, hyperactivity, or impulsivity that are more frequent and severe than what is typically observed in other individuals at the same dev't level.
Attention-Deficit Hyperactivity Disorder
5. If the disorder is characterized by persistent difficulties in reading, writing, arithmetic, or mathematical reasoning skills during formal years of schooling that must be well below the average range of scores in culturally and linguistically appropriate tests of reading, writing, or mathematics.
Specific Learning Disorder
6. If the disorder is characterized by conditions that cause to have abnormal voluntary or involuntary movements, or slow, reduced movements.
Motor Disorder
(developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder)

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1.5 CHAPTER QUESTIONS

1) Explain the contemporary criteria used to define intellectual disability?
2) Give descriptive characteristics of people at each level of intellectual disability?
3) Describe in detail the types of ADHD clients?
4) What is autism and discuss the clinical picture of autism spectrum disorder?
5) What are the biological factors in autism?
6) Write about the ways in which specific learning disorders are diagnosed?
7) Describe the types of specific learning disorders?

1.6 SUGGESTED READINGS

Barlow, D.H., & Durand, V.M. 2007. Abnormal Psychology: An Integrative Approach. Thomson Learning Inc., New Delhi.

Davison, G.C., Neale, J.M., Kring, A.M. Abnormal Psychology, 9th edition. Wiley & Sons:USA.

Wilmshurst, Linda. 2008. Abnormal Child Psychology: A Developmental Perspective. Taylor & Francis Group: New York.

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